

Financial Assistance Policy HS-FIN303

I. PURPOSE

Community Memorial Healthcare (CMH) provides financial assistance to patients who need help paying for their medical care. Financial assistance may be available if you:

- Do not have health insurance.
- Have health insurance but still cannot afford your medical bills.
- Are not eligible for government assistance programs.
- Are experiencing financial hardships.

CMH provides emergency medical care to everyone, regardless of their ability to pay or whether they qualify for financial assistance.

This policy applies to the following locations: Community Memorial Hospital- Ventura and Community Memorial Hospital- Ojai for all emergency, outpatient, and inpatient services provided with the exception of experimental or investigative care and professional medical fees.

II. POLICY

CMH's mission is to give every patient the best possible care every day through healthcare services and medical education. CMH supports the communities where we live and work, including patients facing financial hardship. Our guiding principle is to put patients' needs first.

This policy explains how CMH provides financial help fairly, consistently, and without discrimination to patients who cannot pay all or part of their bills for emergency or other CMH services. Approved patients may receive a full or partial discount or an affordable monthly payment plan.

This policy covers emergency, elective, inpatient, outpatient, and other medical care provided by CMH. It does not cover services from independent providers, such as physicians, radiologists, or anesthesiologists, who send their own bills. It also does not cover services provided at Community Memorial Healthcare Health Centers (clinics). For help paying for these services, contact the provider's office directly.

CMH contacts patients who do not have insurance or whose insurance does not cover the full cost of care. Financial counselors at both hospital locations can help patients

apply for Medi-Cal and CMH financial assistance or set up a payment plan. They can also provide information about local, state, and federal programs that may help pay medical bills.

Financial assistance is available to patients and guarantors who qualify under this policy and applicable federal and state laws. Before starting collection efforts, CMH will make a reasonable effort to determine whether insurance or another third party may pay some or all of the bill. Uninsured patients may receive a discount. Eligible balances may include self-pay charges, charges involving a health plan that does not have a contract with CMH, and coinsurance, deductibles, and copayments. Medicare deductibles and coinsurance reported as Medicare bad debt are not considered charity care.

Patients who want financial assistance must complete a CMH Financial Assistance Application. CMH may also review available information about a patient's or guarantor's income if it suggests financial need. CMH will make reasonable efforts to tell patients about financial assistance during admission and discharge, on billing statements, on the CMH website, during payment discussions, and through signs in registration, inpatient, outpatient, and emergency department areas. CMH will also provide information about community organizations that can help patients understand billing, payment, and possible eligibility for assistance. CMH will keep eligibility records according to its recordkeeping policies.

A. Eligibility And Processing Guidelines

Application Process:

Patients or guarantors can request and submit a free Financial Assistance Application. Applications are available at CMH facilities and at www.mycmh.org. To apply, tell Patient Financial Services staff before admission or discharge, mail the completed application, or download it from the website and submit it with the required documents. CMH will first review whether other payment sources are available and whether the patient may qualify for charity care or a discounted payment plan.

CMH Patient Financial Advocates and Patient Financial Representatives can help patients complete the application and determine whether they qualify for CMH financial assistance or government-funded health coverage, when applicable. Interpreter services are available to answer questions and help patients complete the Financial Assistance Application.

A patient or guarantor who may qualify for financial assistance may submit documents showing that their income is below the applicable federal poverty level under federal and state rules. CMH will pause collection activity while it makes an initial eligibility decision, as long as the patient or guarantor cooperates with reasonable requests for information.

Emergency room physicians who provide emergency services at CMH are required by law to offer discounts to uninsured patients or patients with high medical costs whose family income is at or below 400% of the federal poverty level.

CMH may determine eligibility or apply a discount at any time after learning that a patient's family income, based on family size, is below 400% of the federal poverty level. CMH may also approve financial assistance based only on an initial finding that the patient is indigent. In these cases, supporting documents may not be required.

1. A patient may apply before receiving services if CMH confirms that the services will result in an amount the patient must pay.
2. Financial Assistance is also available for cosmetic procedures that are determined to be medically necessary.
3. If the patient or their representative cannot complete an application, the Director of Patient Access or the Director of Patient Financial Services may decide that the account qualifies for financial assistance.
4. After receiving a completed application, the Director of Patient Access, the Director of Patient Financial Services, or their designee will complete the Financial Assistance Program allowance worksheet and make the final eligibility decision.
5. For patients that qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CMH may offer extended payment plans, see Payment Hierarchy, and will not impose wage garnishments or force a foreclosure on primary residences, will not impose actions that force bankruptcy and will not send unpaid bills to outside collections agencies.
6. CMH will send the patient or guarantor a letter approving or denying the

application within 30 days after receiving the completed application.

Who Qualifies and How Much Debt Is Reduced

1. Debt Reduction:

- a. CMH uses a sliding fee scale based on the current U.S. Federal Poverty Guidelines and the patient's income. Financial assistance is available to all patients, regardless of insurance status, and may cover amounts ranging from Medicare rates up to 100% of total charges. Patients with insurance may receive help with the remaining coinsurance or deductible after insurance pays.
- b. Verification may include, but not limited to, the applicant's most recent federal tax return for the year the applicant was first billed or the year before. CMH may also accept recent pay stubs within six months before or after the applicant was first billed by the hospital or in the case of preservice, when the application was submitted.

2. Patients Who Are Uninsured, Underinsured, or Experiencing Financial Hardship

- a. CMH uses a sliding fee scale based on the current U.S. Federal Poverty Guidelines and the patient's income. Financial assistance is available to all patients, regardless of insurance status, and may cover amounts ranging from Medicare rates up to 100% of total charges. After insurance pays, eligible patients may receive help with coinsurance or deductibles. See the Payment Hierarchy Policy.
- b. CMH will review the application and supporting documents, apply any exclusions in this policy, and decide how much financial assistance the patient qualifies to receive.
- c. Information from the applicant's financial application and supporting documentation will be applied to the list of exclusions to determine the amount of the qualified Financial Assistance to be granted.
- d. Verification may include, but not limited to, the applicant's most recent federal tax return for the year the applicant was first billed or the year before. CMH may also accept recent pay stubs within six months before or after the applicant was first billed by the hospital or in the case of preservice, when the application was submitted.

3. Government Assistance: When deciding whether a patient qualifies for Charity Care, CMH will also consider county and government assistance programs.

- a. CMH works with outside Patient Financial Advocates who can help patients find out whether they qualify for government or other assistance programs.

- b. A patient who is eligible for Medi-Cal, Medicaid, or another government program but was not enrolled when care was provided may still qualify for charity care if the patient now applies for that program. This may be especially helpful when the patient needs ongoing care.
- c. If a patient does not respond to requests to complete the application, CMH may use other available information to assess the patient's financial need.
- d. CMH may use an outside company to review public-record information and estimate a patient's ability to pay. CMH may use this review when the patient has not provided enough information and CMH has already tried to confirm whether insurance or other coverage is available. The review gives CMH a consistent way to grant presumptive eligibility to patients who appear to need financial help.
- e. Assistance granted through this Predictive Model is generally for one time only. Patients who receive presumptive assistance must complete a Financial Assistance Application for future services. A patient who does not qualify through the predictive review may still submit supporting documents and apply through the regular process.

Determinations and Approvals:

CMH will notify the patient of its decision within 30 days after receiving a complete application and all required documents. The Patient Financial Services Supervisor reviews applications each week. A denial letter will explain why the patient did not qualify and how to appeal. Once CMH receives an application, it will pause extraordinary collection efforts until it sends the patient a written decision. CMH will not make a decision using information it believes is incorrect or unreliable.

Dispute Process:

A patient may appeal a denial by sending CMH additional supporting documents within 30 days after receiving the denial letter. The patient may ask the Director of Patient Business Services to review the decision in the event of a dispute. CMH will pause collection activity during the appeal. If CMH upholds the denial, it will send written notice to the guarantor and, when required by law, to the State Department of Health. CMH will complete the final appeal review within 10 days after receiving the appeal. Send appeals to: Community Memorial Healthcare Business Office, Attn: Financial Assistance, 5855 Olivas Park Drive, Ventura, CA 93003.

Reasonable Payment Plan:

If a patient receives a partial discount and still owes a balance, CMH will work with the patient to set up a payment plan. Payments will not include interest or late fees. The monthly payment will not be more than 10% of the patient's or family's monthly income after subtracting the essential living expenses listed on the application. CMH

will extend the payment-plan timeline for patients who have a coverage appeal pending.

Billing and Collections:

After all available discounts are applied, CMH may send an unpaid balance to collections. Before collection begins, CMH or its collection agency will provide the written notice required by California Health and Safety Code section 127430 about rights under the Fair Debt Collection Practices Act. CMH will stop collection efforts while it makes a final decision about financial-assistance eligibility. CMH and its collection agencies do not use extraordinary collection actions. For questions about billing or collections, call the CMH Business Office at (805) 948-2801.

Patient Refunds:

If a patient or guarantor paid for services and is later approved for charity care or discounted care, CMH will refund any amount paid above the amount the patient was required to pay for the eligible period. Refunds will follow state rules.

B. Other Debt Reduction

1. Administrative write-offs will not be considered Charity Care.
2. Bad Debts will not be considered Charity Care.
3. Bad Debt accounts returned by third party collection agencies who have determined the patient/guarantor does not have the ability to pay, in accordance to the Financial Assistance Program policy, will be classified as Charity Care.
4. Accounts reduced to a zero balance as the result of the patient/guarantor being deceased with no estate will be considered Charity Care, as evidenced by supporting documentation.
5. Accounts reduced to zero balance, as the result of bankruptcy will be considered Charity Care.
6. Approval for Financial Assistance and any care provided covered by the Financial Assistance Program does not obligate CMH to provide continuing care.

C. Debt Reduction Authorizations

Each financial assistance application must be approved by the role listed below for the amount requested.

Minimum Amount	Maximum Amount	Role
\$0	\$10,000	Senior Patient Account Rep
\$10,001	\$100,000	Director of Patient Business Services
\$100,001	\$Over	CFO

D. Other Financial Assistance Program Rules

Approval for Financial Assistance and any care provided covered by the Financial Assistance Program does not obligate Community Memorial Healthcare to provide continuing care.

Factors Not Considered:

CMH will not use the following items to decide whether a patient qualifies for financial assistance: bad debt, contractual allowances, perceived underpayments for operations, payments made through charitable contributions, community service or outreach programs, or employment status. These items do not affect eligibility.

Equal Opportunity:

CMH follows federal, state, and local laws that prohibit discrimination when making financial-assistance decisions.

Coverage Period

The Financial Assistance Program covers eligible services provided by CMH hospitals.

A discount may cover services already received and future services provided within 30 days. If the patient or guarantor receives services three months after the original approval, CMH will ask for updated income information.

The Financial Assistance Program does not cover long-term care, assisted living, home medical or durable medical equipment, or other services that hospitals or clinics do not usually provide.

The services listed below may not qualify for charity care. If medically necessary, they

may still qualify for a discounted payment.

- A. **Abortion:** is the termination of a pregnancy by removal or expulsion of an embryo or fetus.
- B. **Acupuncture:** Shiatsu, electrical stimulation to the periosteum, chelation therapy, immunoaugmentive therapy (IAT), thermograph, joint reconstruction therapy, joint sclerotherapy, protho therapy, or ligamentous injections with sclerosing agents, Osteopathic manipulative treatment, spinal manipulative treatment, and kebiozen.
- C. **Complications:** Complications of Non-covered Procedures.
- D. **Cosmetic surgery:** Cosmetic surgery or any complications arising from Cosmetic surgery including; laser treatment or ablation of benign skin lesions [except for condyloma acuminatum], dermabrasion, superficial chemical peels, and medium or deep chemical peels not directed at the treatment of pre-cancerous skin lesions. This exclusion does not apply to: Cosmetic surgery required for correction of a condition arising from an Accidental Injury, or when rendered to correct a congenital anomaly where the correction restores a functional bodily process.
- E. **Custodial care:** Care whose primary purpose is to meet personal rather than medical needs and which can be provided by persons with no special medical skills or training is considered as Custodial Care. Such care includes, but is not limited to:
 - a. Helping a patient walk, get in or out of bed, and take normal self-administered Medicine. Domiciliary care and inpatient hospitalization are not covered for the purposes of Custodial Care.
- F. **Dental treatment:** Routine dental treatment, unless medically necessary due to a serious medical condition or an accidental injury.
- G. **Elective Surgery:** Surgery that is scheduled in advance because it does not involve a medical emergency
- H. **Exercise programs:** Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy.
- I. **Experimental or not Medically Necessary:** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- J. **Gastric surgery:** Any services, supplies, or programs involving gastric surgeries for weight loss.
- K. **Impotence:** Care, treatment, services, supplies or medication in connection with diagnosis and treatment for impotence.
- L. **Infertility:** Care, supplies, services, diagnosis and treatment for infertility, sterility, artificial insemination, embryo transplants and

storage, or in-vitro fertilization

- M. **Massage:** Services from a masseur, physical culturist, physical education instructor, or health club attendant.
- N. **No Physician recommendation:** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the patient is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or sickness.
- O. **Obesity:** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another sickness.
- P. **Occupational:** Charges for or in connection with an Injury or Illness, which is occupational, arises from work for wage or profit including self-employment. This exclusion applies even though the Participant waives or fails to assert his right under the law, or expenses resulting from wage or profit. One example of this is if the individual is self-employed and experiences an Injury or Illness, which arises out of or in the course of that employment, the charges will not be covered by the FAP if the self-employed individual elected not to participate in a Worker's Compensation program, as consistent with any applicable State or Federal Law.
- Q. **Private duty nursing:** Charges in connection with care, treatment or services of a private duty nurse.
- R. **Surgical sterilization:** Elective surgical sterilization procedures.
- S. **Surgical sterilization reversal:** Care and treatment for reversal of surgical sterilization.
- T. **Surrogacy:** Any service associated with any type of surrogacy agreement or arrangement, including traditional surrogacy, artificial insemination related to a surrogacy agreement or arrangement, or gestational or in-vitro fertilization surrogacy.

ATTACHMENT A

Persons in Family or Household	2026 FPG Gross Income 6 Months	200% of FPG Adjustment	201%-300% of FPG	301% and over Refer to Financial Assistance Charity Policy
			Adjustment	
1	\$15,960.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
2	\$21,640.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
3	\$27,320.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
4	\$33,000.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
5	\$38,680.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
6	\$44,360.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
7	\$50,040.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
8	\$55,720.00	100%	Medicare Rates	<i>Refer to Financial Assistance Charity Policy</i>
Each additional	\$5,680.00			

**2026
SCHEDULE
I**

200% of Poverty Guidelines Equals Charity Write Off No Patient Responsibility

Size of Family	Income Guidelines	Income Guidelines	Income Guidelines
Unit	Three Months	Six Months	One Year
1	\$7,980.00	\$15,960.00	\$31,920.00
2	\$10,820.00	\$21,640.00	\$43,280.00
3	\$13,660.00	\$27,320.00	\$54,640.00
4	\$16,500.00	\$33,000.00	\$66,000.00

5	\$19,340.00	\$38,680.00	\$77,360.00
6	\$22,180.00	\$44,360.00	\$88,720.00
7	\$25,020.00	\$50,040.00	\$100,080.00
8	\$27,860.00	\$55,720.00	\$111,440.00

For Family units with more than eight (8) members, add \$11,360.00 for each additional member.

**2026
SCHEDULE
2**

200%-301% of Poverty Guidelines Equals 25% of Charges or Medicare DRG for Inpatient whichever is less

Size of Family	Income Guidelines	Income Guidelines	Income Guidelines
Unit	Three Months	Six Months	One Year

1	\$11,970.00	\$23,940.00	\$47,880.00
2	\$16,230.00	\$32,460.00	\$64,920.00
3	\$20,490.00	\$40,980.00	\$81,960.00
4	\$24,750.00	\$49,500.00	\$99,000.00
5	\$29,010.00	\$58,020.00	\$116,040.00
6	\$33,270.00	\$66,540.00	\$133,080.00
7	\$37,530.00	\$75,060.00	\$150,120.00
8	\$41,790.00	\$83,580.00	\$167,160.00

For Family units with more than eight (8) members, add \$17,040.00 for each additional member.

**2026
SCHEDULE
3**

301%-700% and above Poverty Guidelines Equals a 40% of Charges or Medicare DRG whichever is less

Size of Family	Income Guidelines	Income Guidelines	Income Guidelines
Unit	Three Months	Six Months	One Year

1	\$15,960.00	\$31,920.00	\$63,840.00
2	\$21,640.00	\$43,280.00	\$86,560.00
3	\$27,320.00	\$54,640.00	\$109,280.00
4	\$33,000.00	\$66,000.00	\$132,000.00
5	\$38,680.00	\$77,360.00	\$154,720.00
6	\$44,360.00	\$88,720.00	\$177,440.00
7	\$50,040.00	\$100,080.00	\$200,160.00
8	\$55,720.00	\$111,440.00	\$222,880.00

For Family units with more than eight (8) members, add \$22,720.00 for each additional member.

